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UNITED STATES DISTRICT COURT
DISTRICT OF NEVADA

DANA REIPLINGER, an individual, Plaintiff, vs. SUN LIFE ASSURANCE COMPANY OF CANADA, a Massachusetts company; DOES I – V inclusive; ROES I – V inclusive, Defendants.	Case No.: 2:17-cv-688 **COMPLAINT** **Jury Trial Demanded** **[Claim 030615-05991-00]**

COMES NOW Plaintiff Dana Reiplinger, by and through counsel, Valerie Del Grosso, Esq., of Del Grosso Law, Ltd., and states the following allegations and causes of against Defendant as follows:

1. This is an action for recovery of benefits under a contract.

2. Plaintiff DANA REIPLINGER is an adult resident of Las Vegas, Clark County, Nevada.

3. Defendant, SUN LIFE ASSURANCE COMPANY OF CANADA (hereinafter "SUN LIFE"), was and is a wholly-owned indirect subsidiary of Sun Life Financial, Inc. SUN LIFE is an insurance company doing business in the state of Nevada with its principal place of business and U.S. Headquarters in Wellesley Hills, Massachusetts.

4. That the true names and capacities, whether individual, corporate, associate, or otherwise, of the Defendants named herein as DOES I through V and ROES I through V

Inclusive, are unknown to Plaintiff at this time and Plaintiff, therefore, sues said Defendants by such fictitious names. Plaintiff is informed and believes and therefore alleges, that each of the Defendants designated as DOES and ROES or any other entity, are responsible in some manner or involved in the handling of the subject claim including but not limited to the investigation, determination and/or its resolution and caused damages proximately to Plaintiff as herein alleged, and Plaintiff will ask leave of this court to amend her Complaint to insert the true names and capacities of said DOES and ROES when the same become ascertained, and join said Defendants in this action. This Court maintains subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1332.

5. Plaintiff and/or her employer, MGM Resorts International, purchased through her employer a contract of long term disability (LTD) benefits (hereinafter "the LTD Plan"). Upon information and belief, SUN LIFE investigated and made the decision to deny Plaintiff's disability claim under the subject policy.

6. At all times material to this Complaint, the Plan was in full force and effect and Plaintiff was a Plan participant. Plaintiff made all required payments under the Plan.

7. Defendant, SUN LIFE, is in possession of all master Plan documents.

8. Defendant is a third-party plan administrator or claims fiduciary given discretion to interpret Plan provisions and is a Plan fiduciary, or alternatively, is a plan fiduciary without discretion to interpret Plan provisions.

9. On or about December 12, 2014, Plaintiff became totally disabled from her past Employment (unable to perform the material and substantial duties of her own occupation) as defined by the Plan, due to back pain, lumbago, cervical pain, cervical/lumbar degenerative disc disease, and lumbopelvic pain with leg pain and tingling, and other exertional and nonexertional impairments. While so employed, Plaintiff became disabled due to multiple health issues including but by no means limited to injuries to her back, as well as chronic pain. Plaintiff's disability includes, without limitation, her inability to work forty (40) hours per week.

10. Under the subject policy, "Total Disability" or "Totally Disabled" means "… Employee, because of Injury or Sickness, is unable to perform the Material and Substantial duties of his Own Occupation."

11. Plaintiff's occupation is a Table Games Supervisor, which Defendant categorizes as a "light duty" occupation. The material and substantial duties of a Table Games Supervisor include, *inter alia*, managing three to twelve people at any given time, while overseeing one to five table games hosting multiple players each' communication with guests, supervisors, and subordinates verbally and in writing; to be alert for possible cheating; to calculate, convert, track, and verify payouts quickly and in the moment; to manage problematic situations as they arise in keeping with gaming laws, employer expectations, and customer experience considerations; all in a relatively dark, smoke-filled, crowded, and fast-paced casino-resort environment which requires a long walk to reach her work station, take breaks, and use the restroom. Mrs. Reiplinger stands on a hard concrete floor with thin carpet overlay.

11. On or about July 16, 2015, Plaintiff reached the end of the Elimination Period and became eligible for disability benefits under the Plan.

12. Plaintiff's application for benefits was denied by Defendant or its agents on or about October 5, 2015.

13. Plaintiff timely appealed on Mach 31, 2016, noting, *inter alia*, that Defendant relied on generic vocational data; failed to review or request medical records for the entire period of the condition; failed to request an independent medical examination; and failed to adequately investigate the claim (particularly where the records indicated consistent and lengthy medical history) and to credit reliable evidence, all of which resulted in a denial against the clear weight of the record.

14. On or about May 19, 2016, Defendant requested an independent medical examination and paid one month's benefits under a reservation of rights.

15. Plaintiff appeared for the Independent Medical Examination, which was conducted in a fashion completely differently than any other medical professional (including physical therapists, chiropractors, and orthopedic surgeons) has ever examined Plaintiff.

16. Plaintiff was not allowed to ask questions of the Independent Medical Examiner.

17. On or about September 12, 2016, Defendant upheld its previous denial.

18. Plaintiff continues to remain totally disabled from employment, as defined by the Plan, due to the aforementioned health issues, and other exertional and non-exertional impairments.

19. Plaintiff has exhausted all mandatory administrative remedies afforded by the Plan and has otherwise complied with all conditions precedent to this action.

19. Each of the Defendant's denials of Plaintiff's claims for LTD benefits was arbitrary and capricious, constituted abuse of Defendant's discretion under the Plan, and derogated Plaintiff's right to disability benefits under the terms of the Plan.

20. It is worth noting that Plaintiff's own doctor stated that Plaintiff can no longer work and is disabled as a result of the conditions discussed.

FIRST CAUSE OF ACTION
(Breach of Contract)

21, Plaintiff repeats and realleges the foregoing as if fully set forth herein.

22. Upon information and belief, Defendant also insures the Plan. Defendant's dual capacity creates an inherent conflict of interest as a matter of fact and law. Defendant has improperly, erroneously, arbitrarily and/or capriciously denied Plaintiff benefits due and owing under the Plan. As a result of the denial discussed above, SUN LIFE breached the policy.

23. As a result of SUN LIFE's breach, Plaintiff has incurred special damages in excess of $75,000, in an amount to be determined at trial, including benefits withheld from approximately June, 2015, through the present and continuing, and interest thereon.

24. As a further result of Defendant's breach, Plaintiff has suffered general damages, including anxiety, worry, and mental and emotional distress, all to Plaintiff's general damage in excess of $75,000, in an amount to be determined at trial.

25. As a further results of Defendant's breach, Plaintiff has been forced to retain an attorney and is therefore entitled to reasonable attorney's fees and costs.

SECOND CAUSE OF ACTION

(Breach of Covenant of Good Faith and Fair Dealing and Bad Faith under common law)

26, Plaintiff repeats and realleges the foregoing as if fully set forth herein.

27. Defendant had a duty to fully and fairly investigate the subject claim in good faith.

28. Defendant breached this duty when it determined Plaintiff did not meet the policy requirements, despite her treating physicians' medical opinions to the contrary. Defendant purposefully performed an inadequate investigation into the subject claim, to facilitate claim denial, including, without limitation, by suggesting opioid pain medication would be a satisfactory result (despite the literature showing that this is not a long term solution to chronic back pain and that Plaintiff's profession requires clarity of mind and alertness) and without reviewing a lumbar spine MRI.

29. Defendant breached its duty when it failed to request a Functional Capacity Examination from a qualified professional, particularly in light of its refusal to accept the recommendations and diagnoses of Plaintiff's medical doctor.

30. Defendant failed to consider Plaintiff's own explanation of her symptoms and how they affected her ability to work.

31. For example, Plaintiff explained that she worked with pain as long as she could and could not risk becoming crippled by continuing her job duties. Defendant had no basis to dispute that Plaintiff suffers from chronic pain, but nevertheless ignores it and suggests her pain is normal in a mid-50s, otherwise healthy, woman.

32. Defendant further breached its duty by failing to make any consideration whatsoever regarding Plaintiff's education or experience.

33. Defendant further breached its duty by failing to speak to Plaintiff’s employer or request records, which would have shown Plaintiff’s leaves of absence under FMLA related to her condition.

34. Defendant breached this duty when it ignored objective evidence supporting Plaintiffs restrictions and limitations, as defined under the "proof of claim" provision in the subject policy. That same provision does not limit proof of disability to only "objective evidence." Nevertheless, in order to facilitate claim denial, Defendant ignored both objective and subjective evidence of total disability.

35. Defendant knew Plaintiff had a history of surgeries on her abdomen which could impact her condition. Defendant breached its duty to investigate by failing to inquire in any manner whether they did, including but not limited to, ordering medical records prior to 2009.

36. As a result of Defendant's breach, Plaintiff has incurred special damages in excess of $75,000.00, including benefits withheld from approximately June, 2015, through the present and continuing, and interest thereon.

37. As a further result of Defendant's breach, Plaintiff has suffered general damages, including anxiety, worry, mental and emotional distress, all to Plaintiff’s general damage in the sum in excess of $75,000.00.

38. As a further result of Defendant's breach, Plaintiff has been forced to retain the services of an attorney and is therefore entitled to reasonable attorney's fees and costs.

THIRD CAUSE OF ACTION
(Violation of Nevada Deceptive Trade Practices Act)

39. Plaintiff repeats and reallages the foregoing as if fully set forth herein.

40. Defendant SUN LIFE engaged in unfair trade practices in violation of Nevada’s Deceptive Trade Practices Act by failing, *inter alia,* to provide Plaintiff with a reasonable explanation of the basis in the insurance policy, with respect to the facts of Plaintiff’s claim and the applicable law, for the refusal to pay benefits. NRS 686A.310(n), NAC 686A.675 (1).

Defendant engaged in unfair trade practices by failing to pay benefits when its liability under the subject policy was reasonably clear. NRS 16 686A.310(e).

41. Defendant engaged in unfair trade practices by failing to request an IME when its own claims reviewer stated, “In this case it may be reasonable to consider an [physician] review with a [physical medicine and rehabilitation [PM&R] /pain subspecialty to assess appropriate [restrictions and limitations], duration, outline what would be a reasonable [treatment] plan, and expectation for improvement with or without recommended [treatment].” Defendant never provided information regarding restrictions and limitations, duration, or to outline a treatment plan.

42. Defendant misrepresented to Plaintiff that a “change” in her condition would be required to pay benefits, despite the policy lacking any provision to this point whatsoever. NRS 686A.310(a).

43. Defendant further misrepresented policy provisions by suggesting that her claim may be governed by ERISA, when it in fact knew, or should have known, that it was not. There is absolutely no reference to ERISA in the subject policy.

44. Plaintiff is informed and believes that Defendant intends to and will continue to deny and withhold benefits due Plaintiff unless compelled to pay her benefits by a final judgment of this Court.

45. As a result of Defendant's breach, Plaintiff has incurred special damages in excess of $75,000.00, including benefits withheld from approximately June, 2015 through the present and continuing, and interest thereon.

46. As a further result of Defendant' s breach, Plaintiff has suffered general damages, including anxiety, worry, mental and emotional distress, all to Plaintiff’s general damage in the sum in excess of $75,000.00.

47. Defendant intended its conduct, as described herein, to cause injury to Plaintiff, or Defendant carried on with such conduct in conscious disregard for the rights of Plaintiff, as to subject the Plaintiff to cruel and unjust hardship, such as to constitute malice, oppression, or

fraud under NRS §42.005, thereby entitling Plaintiff to punitive damages in an amount in excess of $75,000.00.

48. As a further result of Defendant's breach, Plaintiff has been forced to retain the services of an attorney and is therefore entitled to reasonable attorney's fees and costs.

WHEREFORE Plaintiff prays for judgment against Defendant for all Plan benefits owing at the time of said judgment, pre-judgment interest, attorney’s fees, costs of this action, and all other relief deemed just and proper by this Court.

DATED this 8th day of March, 2017.

VALERIE DEL GROSSO, ESQ.
Attorney for Plaintiff